UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF NEW YORK

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In re:

Case No. 07-11068

Highgate LTC Management, LLC,

(Chapter 11)

Debtor(s)

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FIFTEENTH REPORT OF THE PATIENT CARE OMBUDSMAN FOR HIGHGATE LTC MANAGEMENT, INC.

Fifteenth Report of the Health Care Ombudsman for Highgate LTC Management, Inc.

For the Reporting Period Beginning August 22, 2009 and ending October 20, 2009

The following report is a compilation of three separate Long Term Care Ombudsman Programs due to the fact that this Bankruptcy proceeding involves three distinct counties with three Long Term Care Ombudsman Coordinators. Each Coordinator is submitting their own report under the appointment of one Coordinator, Edie M. Sennett, Patient Care Ombudsman.

Report of Patient Care Ombudsman Activities for Northwoods Rehabilitation ECF-Hilltop:

The Schenectady County Long Term Care Ombudsman Program continues to provide a regular presence in Northwoods Nursing & Rehabilitation ECF-Hilltop. The number of residents and families reaching out to the newly assigned Ombudsman remains steady and the interaction with the staff continues to be overwhelmingly positive.

During the last sixty days the assigned volunteer Ombudsman has been involved with a number of residents and families in the capacity of an advocate in working with facility administration. Each month the Ombudsman volunteer and Coordinator make a point of speaking with residents and families regarding two main issues, staff communication and call lights. The majority of residents and families are satisfied with the care and few have any complaints with call lights. This was substantiated at the last Resident Council meeting held on Thursday, October 15th as all the residents in attendance explained that the care has been good and staff is readily answering the call lights in a timely manner.

The restructuring of the Social Work department is still a work in progress, but it should be noted that the changes thus far have already had a very positive effect on the quality of intervention and outcome as a result of this new plan. Some other positive feedback that the Program continues to receive has to do with the Dietary/Kitchen Department. Residents and families are extremely pleased with the "dining experience" at the facility and note how hard the director is working in order to accommodate and meet the needs of every resident's wishes.

The Program is very pleased over the fact that the facility has clearly posted all the Ombudsman posters in conspicuous places including the elevators advising residents and families of the Programs presence in the building.

The Ombudsman Program will continue to monitor the facility.

Northwoods Rehabilitation & Extended Care Facility of Cortland:

The Cortland County Long Term Care Ombudsman Program is covering Northwoods of Cortland with two volunteers and the Program Coordinator. Northwoods continues to be visited randomly several days throughout the week including weekends. Since the last report

Northwoods of Cortland has shown a steady decline in the areas of patient care, environmental issues and staff attitudes.

This 200 bed facility has continued to maintain a census above 180 the majority of the time this reporting period. Its allowable capacity is 200. While the facility census has increased from 142 residents in April 2009 to 189 residents in October, there has not been a corresponding increase in staffing. This situation is exacerbated by the facility's continued use of agency (temporary) staff who are not familiar with the residents and their care needs and preferences. As a result, there has been an increasing number of care complaints related to inadequate staff and negative staff attitudes directed at residents and families. This has created an unhealthy environment for residents, many of whom have expressed a reluctance to complain out of frustration or fear. Additionally, the recently hired Director of Social Work resigned. This department has a high turnover rate with nine different people serving that department in the last five years.

During the reporting period the ombudsman program received an increasing number of complaints regarding quality of care and quality of life issues. Many of the complaint issues outlined below are echoed by the Residents' Council, including:

- call bells not being answered in a timely manner, especially on the evening shifts. One family member was called by her relative after waiting fifteen minutes for someone to respond to the call bell. The family member had to resort to an email to the administrator and DON titled "High importance" when the receptionist could not transfer her call to the unit after three attempts in ten minutes. Several residents report that toileting is one of the biggest problems with the lengthy call bell response time. Many are unable to wait and soil themselves. One resident reported that the staff told her they would have to put attends on her.
- residents having to wait long periods of time for medications, treatments and assistance
- negative staff attitudes towards residents and families. In one instance a resident expressed fear of being alone because staff are "mean". Resident Council minutes reflect that many residents feel the staff does not care about them and that they have been made to feel as if they are "bothering" staff when they ask for assistance.
- residents reporting that they are unable to see their doctor when requested, including some complaints that they have never met a physician (two on staff).
- Poor personal care. Examples include: One family member and one resident complain that when peri care is provided, feces remains. On one occasion the LTCOP coordinator visited directly after care was provided and feces was present under the resident's fingernails and the garbage was half full of tissues with feces. The resident stated that she had to "clean the front because they only do the back". This is a repeated complaint. On five different visits, one resident was consistently wet and puddles were noted under his chair on two of the visits. (He is unable to make wants and needs known)

The ombudsman has notified the Department of Health and the Office of the Attorney General about specific complaints for any action those respective entities may deem appropriate. We continue to communicate with the Office of the Attorney General and understand that they are actively investigating at least two of the issues involving resident neglect.

In addition, multiple environmental and physical plant complaints were identified, including:

- drafts coming through windows
- leaky pipes and lack of cold water in some of the rooms
- problems with the elevators. This has affected the timely delivery of resident meals and residents ability to attend activities.
- Offensive urine odors throughout the building which has been a persistent problem for a long period of time
- uncleaned rooms and bathrooms

One room had old dried pureed food on the dresser, bed and mats. The floor was sticky, the fan was dusty and the geri chair was caked with old food. Residents and families complain that bathrooms are not cleaned adequately and feces is often present on the floor and toilet. One family member reported they are cleaning their relative's bathroom.

While the following is not a care issue, it is worth noting that resident council fund raisers were stopped because of an increase in the activity budget indicating that the facility would pay for entertainment. When the bill was submitted to corporate, it was not paid. This resulted in the entertainment being paid with money from the resident council budget. Though the council was assured that they will be reimbursed, it was reported that their balance went from over $1,000 to below $100. It is difficult to surmise if nonpayment to the entertainment would have affected the schedule for the following month.

The Ombudsmen work to communicate regularly with the facility administration to address issues involving resident rights and quality of care as they are identified. Regretfully, it appears that the administration may be becoming overwhelmed with the increasing volume and serious nature of the issues being identified, many of which remained unresolved. This was evidenced by an exchange between the facility administrator and the ombudsman on September 30, 2009 when the administrator walked away from a conversation the ombudsman and DON were having about concerns. He stated that he 'did not want to hear anymore about it '.

Ombudsman Program Recommendations:

- Suspend all admissions until such time as the Patient Care Advocate is satisfied and gives notice of such to this court that the quality of resident care and quality of life of residents have significantly improved. This may include the time necessary for the Office of the Attorney General and/or the Department of Health to complete any current investigations related to quality of care at the facility. This may also include time for the facility to increase and stabilize its direct care and maintenance staff to better meet the needs of and provide a clean environment for the residents currently living at the facility.

- Identify ways to improve staff-to-resident ratios and to retain current facility staff. This will allow continuity of care and help to promote stabilization from administration down.

- Post, in a prominent location, the names and positions of staff actually on duty on each unit, on each shift. Also ensure that staff wear nametags so names can be viewed. This will allow residents and families to know who is providing care.

- Facility wide training in the areas of: 1) Dignity and respect 2) Patient Care 3) Customer Service 4) Culture Change and Diversity. This will promote staff understanding in the areas of sensitivity, negative outcomes of poor care, the importance of good customer service and strategies for working with diverse and non-traditional skilled nursing residents. The ultimate goal of training is to improve the overall quality of life for the residents in Northwoods of Cortland.

- Ensure that residents and families are fully informed about the facilities internal grievance procedure.

Northwoods and Rosewoods Gardens Nursing Homes:

Rosewoods Gardens Visits:

The Ombudsman Coordinator visited the facility at the invitation of the Resident Council President on September 23rd to speak to the Resident Council. The meeting was attended by 12 residents and 1 Activities representative. The Coordinator explained the role of the Ombudsman relative to the residents in the facility. After the presentation the Coordinator walked through the facility. One call bell went off and was addressed within 2 minutes. Staffing appeared to be adequate.

On October 6th, the Ombudsman Coordinator visited the facility to drop off the Bankruptcy Notice to the facility.

Northwoods Gardens Visits:

Since the last court appearance, the Rensselaer County Ombudsman Coordinator has had three other Ombudsmen and the Coordinator rotating through the facility at the request of the State Long Term Care Ombudsman Office.

On September 12th, the Ombudsman Coordinator visited the facility. The staffing numbers were posted on the front bulletin board in the lobby. They included all three shifts as follows: 7-3 shift 1 RN, 5 LPN's, 9 CNA's, 3-11 shift 1 RN, 4 :LPN's, 5 CNAs, 11-7 shift 1 RN, 3 LPN's, 5 CAN's. I spoke with the RN on the second floor and she said the facility was doing well. Staffing was adequate and improving as they were having a job fair at the facility. I spoke with the Resident Council President Shirley Cunningham and she also stated that the facility was getting better. I observed two call bells going off while I was on the second floor and they were answered within two minutes. The bell was turned off after the resident had been attended to.

The Ombudsman Coordinator visited the facility on September 16th. The staffing numbers were posted on the front bulletin board in the lobby. They included all three shifts as follows: 7-3 shift 2 RN's, 5 LPN's, 12 CNA's, 3-11 shift 1 supervisor , 5 LPN's , 10 CNA's, 11-7 shift 1 Supervisor, 3 LPN's, 5 CNA's. The staffing appeared to be adequate, and the dry chalk board had the names of the on duty staff on the second floor. I was asked by a resident if I would follow up on the status of his Veterans benefit and his Medicare $50 a month check. I told him I would and get back to him. This day the facility was having an open house job fair.

On September 19th, the Ombudsman Coordinator visited the facility. The facility staffing was posted in the bulletin board in the front lobby. They included all three shifts as follows: 7-3 shift 2 RN's, 6 LPN's , 9 CNA's, 3-11 shift 1 RN, 3 LPN's, 10 CNA's, 11-7 shift 1RN, 3 LPN's, 5 CAN's. I spoke with the Supervisor on duty; she was very cordial giving me a general description of the facility operation. The staffing was adequate and the facility has incorporated a small dining room on the second floor for residents that need assistance in being fed. I noticed that there were 15 vacant rooms on the first floor and a few on the second floor. I was told by Supervisor on duty that the facility would be starting admissions on Monday.

The Ombudsman Coordinator visited the facility on September 29th. The facility staffing was posted on the front bulletin board in the front lobby. They included all three shifts as follows: 7-3 shift 3 RN's, 7 LPN's, 10 CNA's , 3-11 shift 1 RN, 5 LPN's, 11 CNA's, 11-7 shift 1 RN, 3 LPN's, 6 CNA's. The staffing appeared adequate. The facility census was 88 residents. All staff were wearing name badges. There are still quite a few rooms vacant awaiting new admissions. A walk through the facility indicated adequate staffing and no call bells were noticed ringing for extended periods.

October 6th- Ombudsman Coordinator visited the facility to drop off the Bankruptcy Notice to the facility.

As a result of the concerns and recommendations with regard to the the Northwoods at Cortland facility, the Patient Care Ombudsman respectfully requests a Chambers Conference to discuss these matters.

Respectfully submitted this 13th day of November, 2009

/s/Edie M. Sennett
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